MDR: M4-02-4153-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 8-31-01.
   b. The request was received on 6-25-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFA
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to Request for Medical Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Commission requested two copies of additional documentation via a Fee Letter (MR 116) that was mailed to the Requestor on 7-12-02. No additional documentation was noted in the dispute packet. The Carrier's response is noted as Exhibit II of the Commission case file. All information will be reviewed.

III. PARTIES' POSITIONS

1. Requestor: Position statement taken from Table of Disputed Services:
   "We feel that we [sic] due full and total reimbursements [sic] this equipment we provided to the patient. The insurance carrier originally denied full payment on the claim stating we were paid fair and reasonable. We then provided the carrier per their request a copy of the pre-auth letter agreeing to authorize purchase of the B.G.S. and they still have denied additional payments. We are request [sic] full reimbursement with 'Interest".

2. Respondent: Letter dated 8-23-02:
   "In dispute is the payment amount for durable medical equipment. Provider billed $5,000.00 for a bone growth stimulator under CPT code E0748 and $40.00 for suspenders under CPT code E1399. Carrier has paid $1035 and $8.00 respectively for these items…. By comparison, Medicare in Texas provides only $2684.95 as reimbursement for CPT Code E0748."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-31-01.

2. The carrier denied the billed services as reflected on the EOBs as, "M –NO MAR, REDUCED TO FAIR & REASONABLE RE-EVALUATION NO ADDITIONAL RECOMMENDED ALLOWANCE".

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MAR$	REFERENCE	RATIONALE:
8-31-01	E1399	$40.00	$32.00	M	DOP	Rule 133.307 (g) (3) (D); Section 413.011 (d); HCPCS descriptor	The carrier has denied the disputed equipment as, "M". Section 413.011 states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf." The provider failed to support its position that the fees charged were fair and reasonable as required by Rule 133.307 (g) (3) (D). The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. Rule 133.307 (g) (3) (D) states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" . CPT Code E1399 is defined as "Durable medical equipment, miscellaneous". As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The Provider has failed to submit documentation to support that the fees charged represent fair and reasonable and thereby failed to meet the criteria of Rule 133.307 (g) (3) (D). Therefore, **no additional** reimbursement is recommended
8-31-01	E0748-NU	$5,000.00	$3,965.00	M	DOP	MFG GI (VIII) (A); HCPCS descriptor	The "NU" modifier is not recognized in the Commission's '96 MFG. For this reason, MRD is unable to determine proper reimbursement for the DME in dispute. Therefore, **no** additional reimbursement is recommended.
Totals		$5,040.00	$3,997.00				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 17th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll